**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

RENAISSANCE HOSPITAL
C/O BURTON & HYDE PLLC
PO BOX 684749
AUSTIN TX 78768-4749

**Respondent Name**
NEW HAMPSHIRE INSURANCE COMPANY

**Carrier's Austin Representative Box**
Box Number 19

**MFDR Tracking Number**
M4-08-2044-01

**MFDR Date Received**
November 20, 2007

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "it is our position that we have not been reimbursed at rates as required by the Texas Department of Insurance, Department of Workers Compensation . . . Per TDI/DWC Rule § 134.401 (c) states: A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278) . . . A copy of our Purchase Order for Implants was included in our supporting documentation"

**Amount in Dispute:** $32,903.97

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "This reimbursement was made per a pre-negotiated contract as allowed under Section 413.011(d) of the Texas Labor Code."

**Response Submitted by:** AIG Insurance Service, Inc., 8144 Walnut Hill Lane, Suite 1500, Dallas TX 75231

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 7, 2007 | Outpatient Services | $32,903.97 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of services not identified in an established fee guideline.
3. 28 Texas Administrative Code §134.401 sets out the fee guideline for inpatient services.
4. Texas Labor Code §413.011 sets forth general provisions related to reimbursement policies and guidelines.

5. U.S. Bankruptcy Judge Michael Lynn issued a "STIPULATION AND ORDER GRANTING RELIEF FROM AUTOMATIC STAY TO PERMIT CONTINUANCE AND ADJUDICATION OF DISPUTED WORKERS COMPENSATION CLAIMS BEFORE THE TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS," dated August 27, 2010, in the case of *In re: Renaissance Hospital – Grand Prairie, Inc. d/b/a/ Renaissance Hospital – Grand Prairie, et al.*, in the United States Bankruptcy Court for the Northern District of Texas, Fort Worth Division in Case No. 08-43775-7. The order lifted the automatic stay to allow continuance of the claim adjudication process as to the workers' compensation receivables before SOAH, effective October 1, 2010. The order specified John Dee Spicer as the Chapter 7 trustee of the debtor's estate. By letter dated October 5, 2010, Mr. Spicer provided express written authorization for Cass Burton of the law office of Burton & Hyde, PLLC, PO Box 684749, Austin, Texas 78768-4749, to be the point of contact on Mr. Spicer's behalf relating to matters between and among the debtors and the Division concerning medical fee disputes. The Division will utilize this address in all communications with the requestor regarding this medical fee dispute.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (24) Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
   - 2 – (42) Charges exceed our fee schedule or maximum allowable amount.
   - 3 – (150) Payment adjusted because the payer deems the information submitted does not support this level of service.

**Findings**

1. The insurance carrier reduced payment for the disputed service with reason codes 1 – "(24) Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan." Review of the submitted information found insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. Nevertheless, on June 29, 2011, the Division requested the respondent to provide a copy of the referenced contract(s) between the network and the requestor, pursuant to former 28 Texas Administrative Code §133.307(e)(1), effective December 31, 2006, 31 Texas Register 10314, which states that "The Division may request additional information from either party to review the medical fee issues in dispute. The additional information must be received by the Division no later than 14 days after receipt of this request. If the Division does not receive the requested additional information within 14 days after receipt of the request, then the Division may base its decision on the information available." The respondent did not provide the additional information requested by the Division; therefore, this decision is based on the information available at the time of this review. The above payment reduction reason is not supported. The disputed services will therefore be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The requestor's position statement asserts that "Per TDI/DWC Rule § 134.401 (c) states: A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275,276, and 278)." 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, 22 *Texas Register* 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the medical bill and submitted medical documentation finds no documentation to support that the length of stay exceeded 23 hours. Therefore the disputed services are not inpatient services. Per §134.401(a)(4), "Ambulatory/outpatient surgical care is not covered by this guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing these specific types of reimbursements." Review of the medical documentation finds that the disputed services are outpatient surgical services; therefore, the inpatient fee guidelines in §134.401 are not applicable to the services in dispute. No fee guideline had been issued for these services at the time the services were rendered; accordingly, the services are to be paid at a fair and reasonable rate. The applicable rule for determining reimbursement is found in 28 Texas Administrative Code §134.1.
3. This dispute relates to outpatient services performed in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 2, 2006, Volume 31 *Texas Register*, page 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 *Texas Register* 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement asserts that "Per TDI/DWC Rule § 134.401 (c) states: A) When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275,276, and 278) . . . A copy of our Purchase Order for Implants was included in our supporting documentation."
   - The requestor did not discuss or explain how reimbursement at cost to the hospital plus 10% would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that reimbursement at cost to the hospital plus 10% would result in a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor has not supported that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amounts sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

**Authorized Signature**

| | Grayson Richardson | October 3, 2013 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.